AGING: LIVE AND LET LIVE

WRITINGS IN GERONTOLOGY

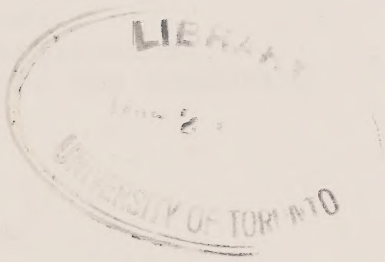
ÉCRITS EN GÉRONTOLOGIE

Government of Canada
National Advisory Council on Aging

Gouvernement du Canada
Conseil consultatif national sur le troisième âge

Canada

AGING: LIVE AND LET LIVE



National Advisory Council on Aging
August 1983

Titles in the Series

1. The Economic Impact of Canada's Retirement Income System

2. Family Role and the Negotiation of Change of the Aged

Information on this report may be obtained from:

National Advisory Council on Aging
Jeanne Mance Building
Ottawa, Ontario
K1A 0K9
(613) 996-6521

Également disponible en français sous le titre:

"Vivre et faire vivre la vieillesse"

Cat. No. H71-2/1-3-1983E
ISBN 0-662-12770-6

TABLE OF CONTENTS

FOREWORD

The Writings in Gerontology series is intended as a vehicle for sharing, with interested Canadians and the public generally, ideas and points of view -- if not contentious issues -- which prevail and may affect the status of elderly persons today and tomorrow.

Texts presented in this series may be adapted or rewritten from original works in order to facilitate comprehension; they may also simply be reprinted for wider circulation. Publication of an article or paper signifies that it is deemed to contain material worthy of public consideration, but does not imply endorsement of conclusions or recommendations by the National Advisory Council on Aging. Such action is part of the Council's role in stimulating discussion and disseminating information on aging.

It is hoped that readers will find the Writings of value for their own pursuits. Also, the Council would welcome comments on the topics selected as well as on the papers themselves.

Maurice Miron, Director
National Advisory Council on Aging

PREFACE

Aging: live and let live is the title of a speech delivered by Dr. Paul David at the "Colloque de l'Association québécoise de gérontologie" at Sherbrooke University, November 18-20, 1982.

Dr. David is an international renowned physician and he is the founder and director of l'Institut de cardiologie de Montréal.

According to Conrad Langlois from the AQG newspaper "Le Gérontophile", Dr. David's speech was the highlight of the first evening of the conference. He had the courage to speak out concerning situations which he found scandalous and he did not fear the repercussions of traditional opinion.

Proceedings of this conference are available at the Secrétariat de l'Association québécoise de gérontologie, 4625, Lorimier Ave., Montréal, Québec, H2H 2B6 ($16.).

The National Advisory Council on Aging is indebted to Dr. Paul David for the use of this material.

1. AGING AND MEDICINE

Old age, you will agree, is a mysterious lottery of life; since the world began, a certain percentage of individuals have always had the luck to live longer than the average. As medicine progressed, this privileged group has increased considerably in size. The principal novelty is not so much individual aging as collective aging; to better understand that phenomenon, it is useful to summarize the major trends in modern medicine and their most obvious consequences.

1A. Trends in modern medicine

I will give you a bird's-eye view of what I perceive as the major changes in medicine in the last 40 or so years, which corresponds more or less to the length of time I have had my diploma in medicine, as I graduated in 1944.

1° The birth of technological medicine

Progress in medicine has always been the result of discoveries in various disciplines: more specifically biology, physics, chemistry and mathematics. The twentieth century will be characterized as a period in which our knowledge in all these fields really exploded, and medicine has benefitted spectacularly from this phenomenon. Thus the medicine of 1940 appears to be empirical and that of today scientific; that of 1940 humanist and

that of today technological. What is true for medicine applies as well to all of our industrial or post-industrial society. These rapid transformations offer considerable advantages, but there are also disadvantages, which we shall attempt to illustrate.

2° Training doctor-scientists

To face the challenge of the new medicine, faculties of medicine have changed their admission criteria to give priority to those students best suited to assimilating the knowledge of the so-called "exact" sciences. Medicine-as-a-science has taken the place of medicine-as-an-art; we have recruited scientists and rejected humanists, hoping that the scientists would also be humanists.

3° Multiplication of specialities and departmentalization of hospitals

In 1940 medicine had essentially two major divisions: the surgeons and the others. There were a few rare specialties: internal medicine, tuberculosis specialists, heart and diabetes specialists, radiologists and pathologists. But it was still the day of big hospital wards, with patients in medical or surgical beds. The saying soon developed: the generalist is someone who

knows nothing about everything and the specialist is someone who knows everything about nothing! Knowing everything became a priority, and an increasingly large priority, as new discovery followed close upon new discovery, at a rate defying one's intellectual capacity to adapt. This led to the extraordinary multiplication of specialties. Thirty-three or so such specialties are now recognized by the Corporation professionnelle des médecins du Québec.

At the same time, hospitals were divided into almost as many subsections within a number of departments. Among these was gerontology, especially since a certain mandatory percentage of beds has been reserved for chronic or elderly patients in the short-term care hospitals, not to mention specialized institutions.

4° Multiplication of the paramedical professions

Still for the same technological reasons, the "generalist" employees in hospitals have also become specialists in the various specialties that have developed. The traditional nursing staff has been joined by specialized staff, generally organized around a support technology or specific medical acts: operating room nurses, intensive care nurses, obstetrical nurses, coronary care nurses, laboratory technicians (biochemistry, blood bank,

bacteriology, hematology), specialists in radiology, in heart-lung machines, inhalation therapists, physiotherapists, occupational therapists, dietitians and so on.

5° The miracles of medicine

This rapid transformation of medical practice has been inspired by the desire to pass on to the population the fruits of the extraordinary progress in medicine. In cardiology alone, think of cardiac catherization, surgery using the artificial heart-lung machine, insertion of artificial heart valves, long-life pacemaker batteries, cardiac resuscitation, coronary dilation and complete heart transplants. How many patients owe extra years of life to these medical miracles? What a disappointment for those who have not yet been able to benefit from them! But really there is no miracle here. This is simply reaping the benefits of progress, however difficult this may be. As Dr. Harry Grantham has said: "There is a risk that health policies will create the illusion that there is an answer for everything. That everything is accessible and cost-effective, and that all one needs in order to be happy is to let oneself be treated."[1] Nevertheless, despite these temporary miracles, the brutal fact remains: death, which we are avoiding prematurely or consciously putting off.

6° The costs of medical progress

These have become considerable and consequently most states in our western world have attempted to distribute them over the population as a whole. In this area, our country has been, and still is, one of the most generous in the world. By socializing care and nationalizing health facilities, Quebec has become a model of "philanthropy" for the population and an example of "overdoing it" for the taxpayer. Government management of care has precipitated two predictable phenomena: unionization of workers within the system and bureaucratization of the innumerable persons responsible for the control, delivery, programming and planning of care. The development of technological progress alone is costly. The cost of overall technological progress has also been increased by the free character of health care and services and its resulting abuses. Since it is difficult - and tantamount to political suicide - to take away a benefit once it is acquired, desperate attempts are being made to get around the obstacles by increased planning through regional and preventive bodies, which maintain the illusion of action while increasing bureaucratization. Among these costs we might emphasize the rapid addition of convalescent,extended care and custodial facilities.

1B. Consequences of this medicine

1° Curative and palliative care

In the forties, pneumonia and tuberculosis were the most frequent causes of death. There were cruel epidemics of poliomyelitis and the cardiac damage caused by rheumatic fever left its mark on many. These and many other diseases have all but disappeared. Gradually, fatal diseases have become categorized under four main headings: cardiac and circulatory diseases, 50%; cancer, 20%; accidents of all kinds, 10%; and other diseases, including old age, 20%.

It is curious, where aging is concerned, to note the reluctance of the medical profession to state this as a cause of death as if it were not normal for a person to die of the most desirable thing possible: having lived a long life. Is this a result of medical practitioners' pride or timidity, or a sign that they see this as a negation of their therapeutic powers? I find personally that death from "wear and tear" is a comforting diagnosis and would be pleased to be able to use that diagnosis as often as possible.

Medicine therefore cures a large number of patients and I could fill a number of pages with examples of this. I agree with the idea that there is no price to curative medicine. But

curative medicine is not the most costly part of medicine! Palliative medicine is a different problem altogether and we are entitled to ask a good many questions about it, questions for which the answers are often hard to find. I refer here to the countless therapies which prolong, for a limited time, some forms of cancer, most of the atherosclerotic diseases, certain organic insufficiencies, and so on. These pathologies are often associated with surgical, radiation or replacement therapy which prolongs the chronicity, although not always providing an enjoyable quality of life.

In 1978 , the Office for Evaluation of Technology, set up by the American Congress in 1972, evaluated only 10% to 20% of medical practices as definitely useful.[2] The examples are numerous and cast some doubt on the slogan: life at any price. I even wonder whether the billions of dollars sunk into these uncertain palliative treatments would not be better used to improve working, living, recreational, sport, dietary, ecological and stress-producing conditions which all play a definite role in some of the so-called diseases of civilization.

2° Birth control

The possibility of avoiding pregnancy by chemical means (the Pill) or physical means (the IUD) is probably the most important medical discovery of this century. Birth control is a vital

priority, in some countries, China for example, since its population of one billion represents one quarter of the population of the entire world. Other countries experienced a spectacular drop in the birth-rate. This has been the case in Quebec. And it represents a threat in the long term to the survival of a cultural group that is isolated in a continent with a population of 250 million. Between 1972 and 1982, the Quebec population went from 6.040 to 6.358 million, an increase of 0.5 per year, compared to the increase for Canada as a whole of 1.2% and for the USA of 1.0%.[3]

3° The aging of the population

Decreasing numbers of births have, by default, increased the average age of our population. Moreover, progress in medicine has increased life expectancy. These two factors together explain the general aging of the population, a phenomenon from which women have benefitted much more than men, since they live eight years longer than men on the average.

4° The aging of the hospital clientele

This is a corollary of the general aging phenomenon. For example, in our centre (which specializes in short-term care), the average age of the adult clientele (those 18 and over) was 46 in 1958-61 and 54 in 1974-77, representing an increase of eight

years in two decades.[4] In introducing this point, I would like to take some time to reflect on certain aspects associated with the diagnosis and treatment of an aging hospital population.

We have been aware for some time that children have different pathologies than adults, the treatment of which call for particular specificities. Thus we witnessed the birth of the specialty of pediatrics and of a large number of sub-specialties. For several years now, an identical phenomenon has been developing for the elderly, and a new specialty, geriatrics, is becoming increasingly important. I am glad of this, because I am convinced that the therapeutic problems of the elderly are different than those of younger adults. Two common phenomena are observed with respect to this group of clientele, a group that is rapidly increasing in size.

Considering the criterion of chronological age alone (age 70 for instance) some doctors adopt an overall conservative attitude, which often results in undertreatment. Others, on the other hand, without considering all of the other factors associated with age, propose high risk treatments, which may not be overtly justified in my opinion, and result in overtreatment. It is no longer a rarity to see these patients receiving coronary bypasses, or valve replacements on the heart-lung machine. And with success heaped on success, the frontiers of age are

retreating. I feel, personally, that a decision involving risk for an elderly person should always be evaluated according to the overall benefits expected and the quality of life desired by the person in question. Medicine for the elderly should first and foremost be humane and holistic. Any other consideration seems to me to be in contradiction to the main objective of medicine which is "primo, non nocere" - in the first place, it should not be harmful.

1C. Euthanasia

Treatment of the elderly poses the question of euthanasia and medical conscience. We are aware of just how popular this topic has become in the press, and the broadcast media. The standard approach is to differentiate the two major aspects of euthanasia: passive and active.

1° Passive euthanasia

This consists in accepting the death of the patient as part of the natural process of the evolution of an illness. Physicians must face this eventuality at all times and acknowledge their inability to change its course. And if the treatment involves administration of a tranquilizer which may depress the respiratory centre, decreasing of suffering is,

nevertheless, the main, and perfectly justifiable objective. For me, this indirect and compassionate euthanasia is part of effective and humane treatment.

2° Active euthanasia

This consists in killing the patient to put an end to his illness. The aim is the death, either at the patient's request or at the request of the family. As was the case with abortion 20 years ago, we are now witnessing a genuine crusade in favour of active euthanasia, which nearly always involves the complicity of a physician. The most noble sentiments are invoked to promote this thesis: freedom to die with dignity, choosing one's death, avoiding suffering, making things easier for the rest of the family, and so on. This is no longer a clandestine movement and it is taking on dimensions that merit our reflection before it is too late. In an article of Le Courrier Médical published on October 26, 1982, we read:

> "Movements for the right to die in dignity, which seek to gain legal recognition of the right of the dying to voluntary active euthanasia and to suicide, now exist in more than 25 countries on all 5 continents. There is a world federation... with headquarters in New York City... and the movement involves close to a third of a million people, five hundred of whom are Canadians, where only five years ago only a handful of people were involved".[5]

The main immediate goal is "a review of legislation to decriminalize voluntary active euthanasia and assistance to suicide"... so that "physicians or others assisting a dying person in ending his/her life may do so without fear of legal consequences". I cannot help but compare this to the evolution in the abortion issue, and think that here again we will end up destroying LIFE on DEMAND, for so-called humanitarian reasons. Our civilization has now accepted the death of children in the womb; it is clearly capable, in this new stage, of promoting the death of the bed-ridden elderly, the inactive disabled and the mentally retarded who are a burden to society. Unless there is an individual and collective coming to our senses, we will harvest the fruits of our selfish materialism.

2. AGE AND SOCIETY

As in medicine, the fantastic technological progress in the rest of society in the twentieth century has meant radical changes in our mores and customs. Think of the telephone, radio and television in the communications field; the automobile and airplane in transportation; freezing and distribution in the food industry; skyscrapers, apartment buildings and electricity in housing; movies and all the related recreational products; automation, data processing and computers in the work place; nuclear weapons in defence; social security programs in political systems and so on.

In Québec we are experiencing, mainly since 1960, only two decades, a virtually complete transformation, a "quiet revolution" that has been terribly effective, transforming our mores, our traditions, our way of life, family values, religious values, massive urbanization, low birth rates, promotion of rights and freedoms. Our proximity with the United States has allowed us to instantly import their progress piecemeal, to profit from their world leadership, and to experience an extraordinary economic prosperity. In this context of plenty, society and governments have equipped themselves with unequalled social and security programs. These have led to the creation of the Welfare State. For some months now we have been experiencing the unpleasant repercussions of this excessive generosity.

Retirement is an example: in the USA in 1950, one hundred workers had to support six retired people, while in 1982 they had to support 30 and the figure will have risen to 50 by the turn of the next century.[6] The Québec budget, which was five billion, one hundred million dollars for 1972-73, rose to approximately twenty-two billion, seven hundred million in 1982-83, a four and a half fold increase in 10 years, and the public debt of Québec has risen from two billion six hundred million to fifteen billion one hundred million in the same period of time, a nearly six-fold increase.[7] These few examples leave me with doubts as to our financial ability to support such expenditures at a time when - and I repeat - our population has increased only 5% over the past 10 years.

Let us now go on to mention some of the changes in our society which affect our seniors:

2A. The family

Traditionally, the old person lived out his/her days with one of his/her children. You know better than I what the situation is nowadays. The family? What family? Young couples, whether married or not, stable or temporary, have all the trouble in the world making their relationship work, and children are few and sometimes divided between two households. Today's elderly

have not known such turbulence. They adapt poorly to such situations and often isolate themselves as couples until the death or illness of one of them puts an end to this. After that, there is extreme solitude. To remedy that situation, the Welfare State has built more and more old age homes. Now, for reasons of safety, care, recreation, it has become natural and normal to place our elderly who have become our golden age citizens, in these "homes of happiness"! In short, society has opted for facility and has institutionalized its elderly. And since the elderly continue to become more elderly, barring accident, they are eventually placed in facilities with a variety of labels, according to whether they are autonomous, semi-autonomous, bed-ridden, terminal and so on.

I was amazed to see that placement of elderly persons in institutions in China simply does not exist there.[8] In this communist country, although the state provides all services, it is unacceptable for a son or daughter to place a parent outside of their home. I have vivid memories of these countless old people bringing their birds outside in their cages at 6 or 7 in the morning to sing to the dawn and then, a little later, walking their grandchild to school. I would have loved to have been a poet or painter to be able to capture my emotions at the sight of these two at the opposite extremes of life, walking along together. In Asian and African countries, they have retained

respect for the elderly, and have accepted their decline and death at home just as the parents accepted the responsibility to raise their children there. Is our societal choice a sign of progress or is it not one of decline in the scale of values which we must ultimately pass on?

2B. Institutionalization

Homes for the aged have, therefore, multiplied. As a member of the jury for the 1982 Department of Social Affairs Award of Excellence to an institution within the Department of Social Affairs network, I read with a great deal of interest the applications from some of these facilities. I am pleased at the considerable effort expended to make the life of these clients as happy as possible. I congratulate all those who have as their primary interest the innovation of creative approaches to break the monotony of daily living in these facilities, living which threatens to just go on and on without any happiness. For caregivers working closely with the elderly, the first concern seems to me to preserve their autonomy, their privacy, their tradition and their freedom. In tandem with the often superficial concerns of interventions I have noted a marked desire for profound change of a nature that would create a conforting, human and self-actualizing atmosphere.

2C. Demedicalization

In a number of facilities, we note a commendable effort toward lessening dependency on drugs, while in others the stress is on the preventive nature of structured medical visits. I feel personally that this prevention allows the administrators to have a clear conscience, while not changing much in the evolution of uncomplicated aging. It runs the risk of multiplying needless examinations and of resulting in prescription of drugs that are not indispensable and are sometimes harmful. I am totally in agreement with Gilles Barbeau and Jean-Yves Julien when they say: "We are convinced that improving the quality of life of our elderly must start with a rational and minimal consumption of medication".[9] Abuse of medication is a real scourge of our society, and in institutions it often provides caregivers with the comfort that they are unconsciously seeking. Monthly mandatory medical consultation therefore seems to me to have little to recommend it. It accentuates the dependency of the elderly person and encroaches on his/her autonomy.

2D. De-institutionalization

I find it reassuring that some centres are trying to develop a foster family network in their community. This alternative returns the senior to the human atmosphere of a home and an

emotional environment that meets his/her needs. This network, centred on an organized facility with structured professional services, seems to me a very progressive concept.

2E. Integration into the community

I have noted some very promising experiments in integrating the aged into community life, in particular, the attempts to bring the aged into contact with children and teenagers. These "twinning" experiments, bringing together two people at opposite ends of their lives, constitute an indispensable link between the young and the old. All that is needed is some creativity to develop the thousand and one ways of integration, so as to put an end to this ghettoizing of the elderly, whom we want to be independent and free while surrounding them with structures that make them dependent.

2F. Recreology

My knowledge has been increased by the discovery of this new specialty and of a new professional: the recreologist. Some of the activities offered to the elderly strike me as "folklore", but I have noted some recreational activities aimed at increasing feelings of self-worth in the older person. An effort is made to take advantage of seniors' experience in life, using their

talents, their trades, etc. associating them with work being done in the facility in which they live: painting, carpentry, repairs, gardening. One could imagine a community television station involving the various institutions and making use of a large number of elderly persons who could speak of their experiences for the benefit of younger generations.

Our western society is wrong in no longer believing in the wisdom, experience, perspicacity, total freedom of expression of those over the age of 65, while many eastern societies have great confidence in these same qualities. I personally feel that the bridging of generations might provide those in charge of our country and our institutions with invaluable assistance in bringing together the population as a whole within realistic concepts of wisdom and vitality.

3. AGE AND PSYCHOLOGY

I venture into this topic with humility but conviction. It is my profound belief that human relationships require an ongoing effort of reciprocal understanding based on a natural or acquired knowledge of evident or hidden psychological principles. The essential means is dialogue, the ability to listen, empathy. These qualities bring out confidence and calm discussion of any situation of concern to the other person.

In current medical practice, doctors often go to excess in diagnosing and treating insignificant conditions; there is a multiplicity of examinations, laboratory tests, x-rays, consultations, to confirm or deny the obvious. There is no longer any confidence without the reassurance of objective proof. It is, in fact, easier and faster to use these expedients - and patients appreciate them a great deal as well - than to listen to them for a long time and discover that their problems have a psychological basis with physical repercussions, or vice versa: stress, conflicts with those around them, some unexpected event or one that has been over-dramatized, anxiety. I have always been stimulated by the thought that the majority of these psychosomatically ill patients were curable if I had the will to see them often and to demonstrate to them, progressively, the importance of the

relationship between the emotional and the physical. In many cases, this rehabilitation was long-lasting and allowed the patient to get on with a normal life with its ups and downs.

It is easy to imagine the countless repercussions of old age on health and behaviour. This is why the attitude of all care-givers requires a predisposition and desire to help them. This adaptation of caregivers to the psychological factors that are involved in the care and needs of the elderly, whether well or ill, explains my opposition to their being placed in short-term general hospitals. Without exception, all the elements liable to make their stay unpleasant are to be found there: choice of physicians, nursing and auxiliary staff, over-medication, inappropriate premises, inadequate organization of recreation. It seems to me almost certain that the elderly are aware of the staff's resentment of their presence. For these reasons I feel it is desirable to put an end to this practice of expediency.

Old age, if it is to be acceptable, must be prepared for psychologically over a long period of time, and for that reason the new legislation allowing everyone to delay retirement if he so desires strikes me as a bad thing. As always, we have made use of sentimental and humane arguments to defend the right to work of those who want to extend their active working life. I am

not certain that this seemingly generous decision does not disguise a desire to protect the "holdings" of the retirement funds, which run the risk of becoming insufficient very quickly, as a result of the excessive financial settlements that have been negotiated in the last 20 years. In so doing, the legislator has forgotten the long preparation that each person must make in advance of this cessation of activities at a given age. There is, in my opinion, much less discrimination in applying a universal measure than in solving individual cases through some arbitration board.

4. AGE AND SPIRITUALITY

Today's old people were born at the end of World War I. They have lived in a Quebec in which religious tradition played an unquestionable role and now have reached a stage in life when the after-life has a very real meaning for them, one of which they are keenly aware. In that context, it is easy to understand their outstanding need for spiritual things. This is why spiritual advisors and others must be particularly careful to provide these people with the HOPE they have such need of to live out their old age with serenity and prepare for a death that is coming closer and closer.

Since death is an unavoidable consequence of life, the longer one's life, the closer one's death. The old person does not need any long speeches to be convinced of that. For this reason, I feel it is essential to de-dramatize the event; instead, every effort must be made to humanize this final step in the voyage of life, so that it will be reassuring, warm, friendly and simple.

In that context, spiritual work with the elderly is particularly comforting, since they are so receptive to the biblical message. At this point in time, dialogue takes on an unwonted importance in people's everyday lives. A thousand and one

initiatives are possible both for the aged and for those working with them, because the latter have a much more frequent contact with death, which will one day be the lot of us all. In that respect, the reflection expressed by the writer in the Royal Bank Newsletter is realistic. It says: "The world would be a better place if people managed to live their lives as if they were about to die".[10]

5. AGE AND VOLUNTEERISM

One of the most positive means of de-institutionalizing homes for the aged, while still retaining them, is to make use of local and community volunteers. It seems to me indispensable to counteract ghettoizing by exploring the thousand and one ways of integrating the elderly into the life of their neighbourhood or city. Volunteer work will be all the more effective if it is based on imaginative, competent and realistic leadership. Its main objective should be the expressed needs of the elderly in the institution. As in many other areas, we have an innate tendency to offer the other person our perception of his/her needs, rather than adapting ourselves to his/her demands and aspirations.

5A. Needs of the elderly in an institution

1° Material needs

These are important to provide the centre with the proper tools for a material life which is comfortable and enjoyable and a gay, clean, welcoming and if possible family atmosphere. Within that context volunteers have their place in canvassing for funds to allow improvement of the quality of life of clients: minibuses, televisions, furniture, gardening tools, physiotherapy equipment, occupational therapy supplies and so on.

2° Recreational needs

The objective of recreation is to break the monotony with occasional distractions: theatre, movies, bingo, special meals, outings, shopping, handicrafts, etc. This form of volunteer work is definitely appreciated and useful.

3° Emotional needs

This, in my opinion, is probably the most difficult and yet the most important kind of volunteer work. We have already spoken of the solitude of the old person whose partner has died, and who has lost most of his friends and acquaintances. Often his children live in another city and have their own problems. Overcoming this solitude is, it seems to me, the most demanding objective of the volunteer. You will no doubt be hearing of a number of experiments, and I might offer you a few suggestions.

A goodly number of volunteers might be chosen from among those in the centre itself, the most autonomous and sociable ones. They might be better than anyone else at transmitting their natural empathy to their less outgoing neighbours, those who are tormented, anxious or isolated. With patience and confidence, we should be able to find a natural and communicative

leader in each centre, who would become the head volunteer in the centre. It would be the responsibility of the centre staff to single out those who would be able to take their own future in hand and think up their own programs.

I can imagine the possibility of several families in a given area associating an old person from the centre with their own family life. This would be a partial foster family, in which human contacts would gradually enrich the emotional needs of all those involved.

It would be interesting to increase the opportunities for contact between children and old people, to have emotional ties between an old person and a child. Each would take pleasure from the other and from giving pleasure to the other. This might be the most frequent means of contact with a family.

In short, any volunteerism might have as its main objective to provide the old person with the desire to live out his days in joy, affection, respect and understanding. This volunteer work based on human relationships seems to be the most likely to reconcile the old person with our rejecting society.

6. CONCLUSION

In my introduction, I spoke of the naïvety and temerity of this presentation. I must thank you for having been so kind as to listen to me and to offer me this opportunity to speak out about what I think about aging. Before long I too will come to the big milestone of 65 and, armed with the strength of my personal convictions, will choose to retire, following many of my devoted colleagues at the Institute who were forced to take retirement in the past. I share the opinion of Lucien Pelletier who wrote: "Our old age will, perhaps, be the richest period in our lives, a period in which we will be filled with memories and take the greatest pleasure in the simplest things. We will have purged our lives of everything that is superfluous and will intensely experience only the essential."[11] I am, to my surprise, anxious to become a citizen who is totally free to act, think, talk, write and organize his time.

In an article in La Vie Médicale au Canada-Français, in May 1982, entitled "Quand j'étais vieux" (When I Was Old), Dr. Paul Claveau saw age as the ultimate stage of serenity "which consists in no longer attaching importance to anything but internal order".[12] I have the impression that I have made some progress in that direction in recent years, and I would like to

be able to communicate that to those who believe in the happiness of our day to day lives despite the many obstacles and annoyances that we encounter.

We have spoken of the aging of individuals and you have no doubt felt that I was often referring to the aging of a civilization. I think, indeed, that our Judeo-christian civilization is showing the wear and tear of its two thousand years. I doubt, however, that modern medicine can cure it, but the world will continue to evolve and new civilizations will gradually come to substitute for ours, identifying themselves with the aspirations of another century.

In this voyage that we are making here on earth, our participation in collective life is an infinitesimal fraction of time, so tiny that it is vital to use it in its entirety in the service of others. For that reason I have always made a point of being available to anyone doing me the honour and pleasure of asking for my presence.

I hope that my old age will increase my availability and will allow me to serve my fellow man with greater wisdom and competency. To grow old is already a privilege of Providence in itself, and that is why life will always be for me an indestructable treasure from birth to a natural death. And when, if ever I

have the great pleasure of outliving the ability to participate in the serenity of my surroundings, I simply wish that those looking after me will have the patience, the kindness, the charity to protect another human life, mindless perhaps, but still a human soul, perhaps one already on the way to Eternity.

BIBLIOGRAPHY

1. Grantham, H. La promotion de la santé, options de valeurs résultant de l'alliance des droits et responsabilités individuels et collectifs. Troisième colloque du Carrefour des Chrétiens du Québec pour la Santé, Montréal, May 29, 1982.

2. McQuaig, L. "La médecine aux frontières de l'interdit". L'Actualité, November 1982, pages 73-78.

3. "Population of Canada by Province, 1972 to 1982". Metropolitan Life Foundation, Statistical Bulletin, April-June 1982, page 15.

4. David, P. and Charbonneau, D. Au coeur des chiffres. Institut de Cardiologie de Montréal, 1979, page 6.

5. "Dans plus de 25 pays: Des sociétés pour le droit de mourir dans la dignité". Le Courrier Médical, October 26, 1982, page 11.

6. Fallows, J. "Entitlements". Atlantic Monthly, November 1982, pages 53-59.

7. Dubuc, Alain, "Déficit: Quel est le point d'alarme?". La Presse, November 13, 1982, pages B1 et B2.

8. Lemire-David, Y. et David, P. "Impressions de Chine". Actualité Médicale, October 6, 1982, pages 56-60.

9. Barbeau, G. et Julien, J.-Y. "L'expérience du Sanatorium Bégin. Médicaments et troisième âge". Carrefour des Affaires Sociales, vol. 4, n^{o} 3, June 1982, pages 24-28.

10. Bulletin de la Banque Royale du Canada. "Regarder la mort en face", Vol. 63, n^{o} 3, May-June 1982.

11. Pelletier, L. "Quatrième âge... Déchéance ou Apothéose". Éditions Anne Sigier, 1982, page 14.

12. Claveau, P. "Quand j'étais vieux", La Vie Médicale au Canada-Français, vol. 11, May 1982, pages 257-262.